REPORT TO THE TWENTY-SECOND LEGISLATURE
STATE OF HAWAII
2003

ON SENATE CONCURRENT RESOLUTION NO.16 S. D. 1, H. D. 1, 2003 LEGISLATIVE SESSION, REQUESTING THE DEPARTMENT OF HEALTH TO SUBMIT TO THE LEGISLATURE A REPORT ON THE DEVELOPMENT OF PUBLIC HEALTH STRATEGIES TO ADDRESS THE HEPATITIS C PROBLEM IN HAWAII.

PREPARED BY:

STATE OF HAWAII
DEPARTMENT OF HEALTH
DECEMBER 2003

REPORT TO THE STATE LEGISLATURE

IN COMPLIANCE WITH SENATE CONCURRENT RESOLUTION NO. 16 S.D. 1, H.D.1

Requesting the Department of Health to submit to the legislature a report on the development of public health strategies addressing the hepatitis C problem in Hawaii.

INTRODUCTION

Hepatitis C virus (HCV) infection is the most common chronic blood borne viral infection in the United States. A national survey, the third National Health and Nutrition Examination Survey (NHANES III), of the civilian, non-institutionalized U.S. population found that 1.8 percent of Americans (3.9 million) have been infected with HCV, of whom most (2.7 million) are chronically infected with HCV. These estimates of prevalence are likely conservative, because the survey excluded incarcerated and homeless persons, groups that have high prevalence of HCV infection. Many of these individuals are not aware of their infection and are not clinically ill. However, the consequences of chronic liver disease from hepatitis C do not become apparent until 10 to 20 years after infection.[1]

Each year an estimated 10,000 to 12,000 Americans die from the effects of HCV and that number is estimated to rise to 30,000 by 2010. HCV is the source of one-third of liver cancer cases and it is the leading cause for liver transplantations in the United States. The virus infects an estimated 20 to 30 percent of people living with HIV and accounts for 25 percent of deaths in people living with AIDS. The estimated annual cost of HCV to society in lost wages and medical care is estimated at more than $600 million. [2]

Individuals who injected drugs, even if they did so on only one occasion many years ago, are at highest risk for HCV infection. HCV infection is rapidly acquired following the initiation of injection drug use and occurs from the sharing of needles, syringes, or other equipment associated with drug use. Of persons injecting drugs for at least 5 years, 70 percent to 90 percent are infected with HCV compared to about 30 percent infected with HIV. The high rate of HCV infection among injection drug users is also reflected in the high rates (15 percent to 40 percent) of HCV infection found among incarcerated persons. More than 80 percent of the nation's estimated 1.7 million current injecting drug users have been incarcerated.[3]

Prior to the mid-1980's there was a 7 percent to 10 percent risk of non-A, non-B hepatitis (hepatitis C) from blood transfusion. This risk declined by more than 50 percent between 1985 and 1990 as a result of implementation of blood donor screening for HIV and surrogate testing for non-A, non-B hepatitis. In 1990, specific donor screening for HCV was implemented and by 1992 the risk of HCV infection from a unit of transfused blood was reduced to one in 100,000.

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[1] National Hepatitis Prevention Strategy, www.cdc.gov/ncidod/diseases/hepatitis/c/plan

[2] Hepatitis Nutrition, Medicine, & Exercise Spring/Summer 2003, www.numedx.com

[3] National Hepatitis Prevention Strategy, www.cdc.gov/ncidod/diseases/hepatitis/c/plan

As of 2001, the risk of HCV infection from a unit of transfused blood is less than one per million transfused units. [4]

Sexual exposures account for about 15 percent of cases of hepatitis C. Because the efficiency of sexual transmission of HCV is low, HCV-positive persons who are monogamous do not need to change their sexual practices. People who are HCV-positive are encouraged to discuss the risk, which is low but not absent, and the use of barrier precautions with their partner. HCV-positive people with multiple sex partners should use latex condoms correctly and every time to protect themselves and their partners from diseases spread through sexual activity. [5]

About 15 percent to 25 percent of persons with acute hepatitis C resolve their infection without further problems. The remainder develop a chronic infection and about 60 percent to 70 percent of these persons develop chronic hepatitis. Cirrhosis of the liver develops in 10 percent to 20 percent of persons with chronic hepatitis C over a period of 20-30 years, and hepatocellular carcinoma (liver cancer) in 1 percent to 5 percent. Chronic liver disease is the tenth leading cause of death among adults in the United States. It is estimated that 40 percent to 60 percent of chronic liver disease is due to hepatitis C and HCV-associated chronic liver disease is the most frequent indication for liver transplantation among adults.[6]

Treatment for hepatitis C should be discussed with a health care provider. Recommended treatments include a combination of pegylated interferon and ribavirin. More information regarding treatment can be found in the 2002 National Institutes of Health Consensus Statement at www.consensus.nih.gov/cons/116/Hepc091202.pdf.

On January 22, 1998, the Secretary of the Department of Health and Human Services requested the Centers for Disease Control and Prevention (CDC) to develop a comprehensive plan to address the prevention and control of HCV infection and its consequences. The National Hepatitis C Prevention Strategy is CDC's response to this request. The principle components of the National Hepatitis C Prevention Strategy are:

- Education of health care and public health professionals to improve the identification of persons at risk for HCV infection and ensure appropriate counseling, diagnosis, medical management, and treatment;
- Education of the public and persons at risk for infection about risk factors for HCV transmission, and the need for testing and medical evaluation
- Clinical and public health activities to identify, counsel, and test persons at risk for HCV infection, and medical evaluation or referral for those found to be infected;
- Outreach and community-based programs to prevent practices that put people at risk for HCV infection, and to identify persons who need to get tested;

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[4] National Hepatitis Prevention Strategy, www.cdc.gov/ncidod/diseases/hepatitis/c/plan

[5] CDC Recommendations for prevention and control of hepatitis C virus (HCV) infection and HCV-related chronic disease. MMWR 1998;47(No.RR-19).

[6]National Hepatitis Prevention Strategy, www.cdc.gov/ncidod/diseases/hepatitis/c/plan

- Surveillance to monitor acute and chronic disease trends and evaluate the effectiveness of prevention and medical care activities; and
- Research to better guide prevention efforts.

Currently, no federal funding is available to support nationwide establishment of hepatitis C counseling and testing services at the state or local level. In response to this lack of federal funding, a number of state and local health departments have funded hepatitis C counseling and testing projects.

A major goal of the National Hepatitis C Prevention Strategy is funding of a Hepatitis C Coordinator for every state and large metropolitan health department to meet the expressed needs of state and local public health officials. The Hepatitis C Coordinator provides the management, networking, and technical expertise required for successful integration of hepatitis C prevention and control activities into existing public health programs. Coordinators assist state or local health departments in: 1) identifying public health and clinical activities in which HCV counseling and testing should be incorporated; 2) ensuring training of health care professionals in effective hepatitis C prevention activities; 3) developing the capacity to provide HCV testing through public health or private diagnostic laboratories; 4) identifying sources for appropriate medical referral of HCV positive persons; 5) ensuring appropriate surveillance for HCV infection; and 6) evaluating the effectiveness of HCV prevention activities.

The similar modes of transmission of HIV, Hepatitis B and Hepatitis C present a unique opportunity to provide prevention services at a single client visit. Integration of services to prevent blood borne viral infections is a relatively new concept. There is limited experience with combining counseling, testing, prevention, immunization, and treatment services for these diseases in HIV/AIDS prevention sites, STD clinics, drug treatment sites, and correctional health programs. However, data from several demonstration projects indicate that integration of HCV counseling and testing into existing public health programs is feasible and may enhance identification of persons with risk behaviors for other blood borne virus infections, such as HIV and HBV.

In June 2002 a Hepatitis C Coordinator was hired as part of the STD/AIDS Prevention Branch to begin the process of integrating hepatitis prevention into public health programs that serve adults at-risk for HIV, Sexually Transmitted Diseases, and Hepatitis. This position is funded by the CDC and the Epidemiology and Lab Capacity (ELC) grant.

Hepatitis C Report

Senate Concurrent Resolution 16, S.D. 1, H.D. 1, 2003 requested the Department of Health to develop public health strategies to address the hepatitis C by reporting on the following six issues:

1. Develop a plan to address hepatitis C and work collaboratively with community-based organizations and health providers.

The State of Hawaii Department of Health (DOH), with the recommendation of the Centers of Disease Control and Prevention, identified the need for a strategic plan for hepatitis C to address the areas of surveillance, education, prevention, care, treatment, and support. In developing the initial draft of the Strategic Plan, the Hawaii Department of Health formed a committee comprised of local public health officials, hepatitis C advocates, physicians and other health care providers, public health educators, university and medical research personnel, correctional health system representatives, military and veteran health service providers, pharmaceutical representatives, and other community stakeholders. During the meetings, recommendations were made about issues regarding hepatitis C in Hawaii.

Beginning in January 2003, three follow-up sessions with the strategic planning committee were conducted. At each session participants were divided into three smaller planning groups to examine current hepatitis C activities within the state and developed specific components of the strategic plan.

The timeframe for the Strategic Plan is three years. The strategic plan will serve as a road map to guide the community, policy makers, and prevention and service organizations to assess needs, prioritize issues, and direct decision-making. The purpose of the strategic plan is to:

1. Document significant facts relating to the epidemic of hepatitis C in Hawaii.
2. Clearly identify a vision and mission statement for hepatitis C in Hawaii.
3. Define goals and objectives in surveillance, prevention and medical management of hepatitis C infection.
4. Outline guidelines for achieving recommended goals and implementing and evaluating specific actions.

The final strategic plan document was submitted to the STD/AIDS Prevention Branch of the Department of Health in September 2003. Quarterly strategic planning committee meetings are planned to provide updates on activities and to reassess current goals, objectives and action steps.

2. Conduct surveillance to monitor and evaluate the epidemiology of infection rates for hepatitis C.

Hepatitis C became a reportable disease in Hawaii in October 1997. The infection is on the list of notifiable diseases to be reported by all health care providers and clinical laboratories to the DOH. The DOH created a hepatitis C registry to track all positive test reports that come from physicians, laboratories and other health care facilities such as Tripler Army Medical Center,

The Veteran's Administration, Correctional Facilities, Drug Addiction Services of Hawaii, and the Diamond Head Health Center STD Clinic.

A cumulative report of positive hepatitis C tests from 1998-2002 indicate the following:

Island	Number (%) of Positive Hepatitis C Tests
Oahu	4,111 (84%)
Big Island	424 (7%)
Maui	350 (6%)
Kauai	132 (2%)
Molokai	6 (1%)

The Department of Health will continue to work with the appropriate health professional organizations to educate health care providers in reporting acute and chronic hepatitis C positive test results.

3. Consider integrating prevention and education activities into state and local public health programs for individuals at greatest risk & assessing costs of these activities.

The Hepatitis C Coordinator has collaborated with other organizations and agencies to determine what resources may be shared to plan, develop, implement and evaluate prevention and education programs.

Prevention and education programs that have been conducted since June 2002 include:

- Hepatitis C Train-the-Trainer Workshop: This workshop was presented by the Hepatitis C Support Project in San Francisco, California and was made possible by a community development grant from Roche Laboratories. The workshop certified 30 community-based health workers as basic hepatitis C educators for a period of one year. The premise of the training was that certified trainers would return to their communities or organizations and educate others about viral hepatitis, particularly hepatitis C. A follow-up education presentation is tentatively being planned for April 2004 with the Hepatitis C Support Project.

- Hepatitis A & B Vaccination Initiative: A process evaluation of the hepatitis vaccine initiative that was developed in 2001 identified barriers for at-risk adults who were eligible to receive state-funded hepatitis A & B vaccines. A key obstacle was that clients were getting lost in a system that required multiple referrals in order to obtain the vaccines. Beginning in November 2002, a work group was formed to revise the initiative by adding the component of training the Epidemiological Specialists III (HIV Counselor/Testers) within the STD/AIDS Prevention Branch of the Department of Health. Updated information included a training and practicum module for the Epidemiological Specialists, revised standing orders and the development of a protocol book. As of November 2003, six HIV Counselor/Testers on 4 islands will have been trained in vaccine administration. The program will have an on-going quality assurance segment to ensure continuity and compliance with the protocol standards. A database to track the number of vaccines administered is scheduled to be in place by December 31, 2003.

- Hepatitis Prevention Services to clients of the Hawaii Syringe Exchange Program: As stated in the introduction, injection drug use has been identified as a primary method for acquiring the hepatitis C virus by sharing syringes and other equipment. This population is also marginalized by the health care system and often does not receive recommended prevention services. A program was developed between the Hawaii syringe exchange program and the Department of Health to provide this at-risk population with hepatitis education, hepatitis A & B vaccinations, hepatitis C testing and HIV testing. The program began with the peer education group of the Hawaii syringe exchange program in Hilo, Hawaii. Programs were conducted during October 2002, January 2003, and April 2003. In October 2003, the hepatitis program was expanded to the island of Oahu. Information regarding the hepatitis programs is outlined in Table 1.

4. Consider counseling/testing persons at greatest risk for HCV infection and assessing the costs related to these activities.

Various tests are available to diagnose and monitor hepatitis C infection. Tests that detect antibodies against hepatitis C and are used in the initial screening process and secondary confirmation include the enzyme immunoassay (EIA) and the recombinant immunoblot assay (RIBA) respectively. EIA tests are reproducible, inexpensive, and FDA-approved for screening at-risk populations and are recommended as the initial test for people with clinical liver disease. A negative EIA test is sufficient to exclude a diagnosis of chronic hepatitis C virus infection in people without other immune disorders. Qualitative hepatitis C virus RNA assays are indicated for confirmation of an antibody test and therapeutic monitoring during treatment. Quantitative hepatitis C virus RNA tests are indicated to determine viral load. Additional analysis includes serial testing for serum liver enzyme levels to determine trends over time and liver biopsy to provide a histological assessment. Because most people with chronic hepatitis C infection have yet to be diagnosed but are likely to come to medical attention in the next decade, a fourfold increase in the number of adults diagnosed with chronic hepatitis C infection is projected from 1990 to 2015.

Laboratory cost data from the St. Francis Liver Center in Honolulu, Hawaii indicates the following:

- Hepatitis C Antibody Test = $19.94
- Hepatitis C RNA Test = $59.85
- Subsequent Liver Enzyme panel = $11.42
- Liver ultrasound = $172.22 (includes hospital and physician fees)
- Liver Biopsy = $578.61(Includes physician, hospital, and pathology fees based on the 2003 Medicare fee schedule)
- Laboratory Tests for patients on treatment for hepatitis C = $93.96 (patients are seen monthly during treatment)

Currently, the State Laboratory does not perform hepatitis C analysis in the public health setting. Conversations with the State Laboratory have indicated that laboratory tests for hepatitis B are being sent to the Oregon state public health laboratory. Reasons for this include a shorter turn-around time for results and a more comprehensive data information system. This venue is also cheaper than laboratory tests with private laboratories. Currently, if a person wants to be tested

for hepatitis C, he/she must do so through the private health care or community health care system. As mentioned in the introduction, there is no nationwide establishment of continually funded, sustained hepatitis programs. The Department of Health will continue to look into possible funding sources and ways to build the infrastructure needed for a successful long-term counseling/testing program in the public setting.

People who have ever used injection drugs and people who currently use injection drugs are at greater risk for acquiring the hepatitis C virus. The STD/AIDS Prevention Branch had an opportunity to use HIV Prevention funds to purchase 150 hepatitis C Home Access testing kits. The test kits are from the Home Access Corporation and consist of a "finger stick" to obtain the blood sample. The sample is handled according to protocol and sent via Federal Express to the contracted laboratory.

The prevention funds are to be spent by the end of calendar year 2003 and will be used as a pilot project to develop protocols for integrating hepatitis C counseling and testing with other prevention services for this at-risk population. It is thought that development of these protocols will serve to facilitate the expansion of hepatitis C counseling and testing into other public health program arenas. It is anticipated that protocol development will be completed by March 2004 to allow for testing and counseling to begin in the spring of 2004.

5. Consider the availability of hepatitis C-related treatment for those cases where treatment is indicated and assessing costs related to making these services available to those who otherwise would not have access to treatment services.

The recommended medical therapy for hepatitis C is a regimen of pegylated interferon in combination with ribavirin. Research studies have shown that combination therapy has resulted in better treatment responses than monotherapy. Genotype determinations also influence treatment decisions. At this time, the best indicator for effective treatment is a sustained viral response, defined by the absence of detectable hepatitis C virus RNA in the serum at 24 weeks after the end of treatment.

According to the Medical Letter (March 2003), costs for the combination therapy PegIntron and ribavirin medication is $30,600 and costs for the combination therapy Pegasys and ribavirin is $27,400. These cost estimates are for the 48-week course of treating the more common genotype 1. Cost data from St. Francis Liver Center in Honolulu, Hawaii indicates that the cost of the first office visit is $222.53 and subsequent office visits are $175.17.

Total lifetime costs, excluding liver transplantation, for hepatitis C has been estimated at $100,000 per patient. Liver transplant costs are estimated at approximately $280,000 each. Conservative estimates place the costs of lost-productivity and medical care from hepatitis C infection in the United States to be in excess of $600 million annually. These costs will increase dramatically as more people with hepatitis C experience complications and seek treatment over the next decade. It is estimated that for the period between 2010 and 2019 that costs for hepatitis C will be $83 billion annually. This is attributed to new diagnosis of existing disease. Of this,

$10 billion represents a low estimate of medical costs and $73 billion represents lost productivity and disability costs. [7]

Data regarding Medicaid fee-for-service hepatitis C treatment costs from 276 paid claims for calendar year 2002 from the Hawaii Department of Human Services Med-QUEST Division indicate a cost of $294,469. (See Table 2)

The current generation of hepatitis C virus treatment and therapies elicits a number of questions regarding which people to treat and who will treat them. Results from a survey of 172 community-based internists and family physicians in the metropolitan Philadelphia inquiring about current practices for diagnosing and treating hepatitis C infection concluded that primary care providers should have a clear understanding of who and how to test for hepatitis C viral infection. Primary care providers are the most likely to have the first encounter with a person who does not know he or she is infected with hepatitis C. The study predicts that as increasing numbers of chronically hepatitis C infected people enter the health care system, they will overwhelm the capacity of specialists and primary care providers will need to play a larger role in the treatment and management of people with hepatitis C.

A survey of 327 medical providers in Multnomah County, Oregon indicated that when asked to describe their level of confidence in their knowledge of hepatitis C on a scale of 1 to 5, with 5 being more confident, there was a mean response of 3.18. The mean response when asked to rate their confidence in managing hepatitis C positive clients was 2.37. The survey also indicated that 66.2% of providers stated that none of their hepatitis C positive patients declined recommended treatment due to cost. On average, providers said that 35.3% of their clients had Medicaid coverage, 7.2% had Medicare, 23.5% had private insurance and 10.1% were self pay (no insurance).

Hawaii is experiencing many of the same challenges. Although the University of Hawaii has a medical school, there is no direct teaching hospital affiliation, and thus area hospitals are contracted to provide research and teaching experience. Internal Medicine residency training is available, but there is no subspecialty training offered in either gastroenterology or hepatology. The Liver Center at St. Francis Medical Center was started in 1991 to serve increasing needs of liver disease in Hawaii. Patients are referred from private practices throughout the islands for care at the Liver Center with the only other provider being the Veteran's Administration Hospital. Current figures indicate that the Liver Center is caring for 1200 people with hepatitis C, or 52% of their patient population. There are nearly 300 patients on the waiting list to be seen for the initial evaluation with a wait time of 4-5 months. (The Liver Center is planning to implement an education and training program for patients and their families to ease the bottleneck of patients waiting for their initial evaluation. The program is anticipated to begin in December 2003).

The two major drug manufacturers of hepatitis therapies, Roche Laboratories and Schering-Plough, have patient assistance programs to help qualified people with the cost of medications for hepatitis C. Schering-Plough estimates that about 25 percent of 200,000 people receiving

[7] 2000 Annual meeting of the American Association for the Study of Liver Disease (AASLD)

their company's treatment for hepatitis C utilize the assistance program for free medications. Data were not available for release from Roche Laboratories.

An overwhelming number of infections are in the nation's prisons where many are incarcerated on drug charges. According to the National Commission on Correctional Health Care 2002 report to Congress about inmate health care, an estimated 17 to 18.6 percent of prisoners are hepatitis C positive. The Centers for Disease Control and Prevention estimates that 1.3 million people with hepatitis C were released from prison in 1996. Nationally, efforts to provide screening, prevention, or treatment have been inconsistent. Many correctional facilities require that in order to qualify for drug treatment, inmates be more than two years from parole and that they enroll in substance abuse courses. It is estimated that 99 percent of all prisoners will eventually be released. In the year 2000, more than 8 million inmates were released back into their communities. Inmates who are not educated about hepatitis risk behaviors are more likely to carry and transmit the hepatitis C virus to others.[8]

In Hawaii, it is estimated that one third of the inmates are infected with hepatitis C. During the last year-and-a-half at Halawa Correctional Facility, 43 percent of the first 600 people tested were positive for hepatitis C infection. This is an increase of previous studies conducted by the Department of Health that indicated an infection rate of 30-35 percent.

When a person enters a jail, their basic medical needs are attended to, usually without long-term planning due to the uncertainty of their length of stay. All inmates receive primary health care services by full time physicians within the Department of Public Safety. All inmates immunized against the hepatitis B virus. Hepatitis A vaccine is offered to all inmates who have hepatitis C infection. Hepatitis C screening is conducted only through patient or provider request.

Halawa Correctional Facility began treating inmates for hepatitis C in April 2000. On Oahu, liver biopsies are performed by the St. Francis Liver Center and then care is returned to the physicians within the Department of Public Safety. The treatment protocol is being revised to state that a person with a history of substance abuse will be considered for inclusion into treatment so long as the patient has abstained from using any abused substance for at least six months. Inmates receiving methadone within the past year will be considered for inclusion and will be tested upon entry and at random intervals every 2-3 months. Only a few inmates have had their treatment discontinued because of drug use. Inmates are encouraged to actively pursue enrollment and participation in an onsite substance abuse program. Another criterion is that the person must have at least one year to 18 months left in the system or that documentation can be provided that the person has insurance or an outside provider who will continue with his treatment. If an inmate leaves prior to the completion of treatment, a 30-day supply of medications is given and he is instructed to apply for Med Quest and to find a health care provider as soon as possible. An inmate's mental health condition is also evaluated before initiating treatment for hepatitis C.

For inmates receiving treatment for hepatitis C, medication is nurse administered and all injections are done at the medical unit. Lab draws are done at weeks 1, 2, 4, and then every four

[8] Hepatitis Nutrition, Medicine and Exercise Spring/Summer 2003; www.numedx.com

weeks after that. Once treatment is completed, the patient continues to be monitored by a provider and follow-up labs are done at week 4, 8, and 12, with a full panel again at week 24. Continuity of care is assured whenever a patient transfers to another state or mainland facility. Since April 2000, 90 inmates have been started on therapy for hepatitis C. Approximately 20 people have completed therapy with the virus remaining undetectable at 24 weeks after completion of treatment.

6. Promote professional education of health care professionals based on current information concerning diagnosis, medical management & prevention recently described by CDC & NIH

The Hepatitis C Coordinator will continue to collaborate with community resources to promote local and national educational opportunities for health care professionals in expanding knowledge related to the diagnosis, medical management and prevention of hepatitis C. The Branch is planning to provide links on the newly designed Department of Health website to national organizations, such as the Centers for Disease Control and Prevention that provide educational resources for health care providers.

Beginning in May 2003, Dr. Naoky Tsai, a liver expert at the St. Francis Medical Center Liver Center, participated as a guest lecturer at the annual HIV/AIDS Update Conference on Kauai and Maui to talk with health care providers in the diagnosis and treatment of hepatitis C. It is anticipated that he will become an integral part of the conferences in the future.

Beginning in December 2003, the Liver Center at the St. Francis Medical Center will initiate an education and training program focused both on patients and health care providers. One objective of the program is to develop a curriculum to educate patients about prevention and self-care behaviors while they are waiting to be evaluated for hepatitis C treatment. A second objective of the program is to develop a curriculum to educate primary and specialty health care providers in the assessment and diagnosis of hepatitis C. The DOH Hepatitis C Coordinator is participating in a dialogue with the Liver Center to establish a partnership between public and private sectors in addressing the complexities of hepatitis C diagnosis.

An article on hepatitis C was submitted by the Hepatitis C Coordinator for publication in the November/December 2003 issue of the Communicable Disease Report. The article was directed at health care providers to give updated information from the 2002 NIH Consensus Report on hepatitis C diagnosis and treatment.

Conclusion

The complexities of hepatitis C pose challenges to public and private health systems. Through increased advocacy at community, state, and federal levels, the problem of hepatitis C is increasingly recognized. The United States Congress is proposing legislation to establish, promote and support a comprehensive prevention, research, and medical management program for hepatitis C virus infection. The passage of this legislation would provide a federal directive under the Department of Health and Human Services to provide hepatitis C services, particularly for underserved and disproportionately affected populations. The Hawaii Department of Health

will continue to work at addressing the components of the Centers for Disease Control and Prevention National Prevention Strategy for hepatitis C and to build upon the successes of the six issues as outlined in this report.

Table 1: Hawaii Syringe Exchange Hepatitis Program

	October 31, 2002	January 22, 2003	April 9, 2003	October 31, 2003 (Oahu)	Totals
People Participating	**11**	**6**	**3**	**25**	**45**
Hepatitis A Vaccine #1	**5**	**1**	**2**	**9**	**17**
Hepatitis A Vaccine #2	**NA**	**NA**	**1**	**NA**	**1**
Hepatitis B Vaccine #1	**1**	**0**	**0**	**4**	**5**
Hepatitis B Vaccine #2	**NA**	**1**	**1**	**NA**	**2**
Hepatitis B Vaccine #3 *	**NA**	**3**	**1**	**NA**	**4**
Hepatitis C Tests	**4**	**3**	**2**	**4**	**13**
HIV Tests	**2**	**	**2**	**6**	**10**

*Some participants provided documentation of receiving the previous two doses of hepatitis B vaccine on this date.

**HIV Counselor/Tester Not Available

Table 2: Medicaid Fee-for-Service Hepatitis C Treatment Paid Claims for Calendar Year 2002

Drug Name	Count of Scripts	Paid Amount
INTRON A 10MMMU VIAL	1	$1,598.81
INTRON A 10MMU/ML VIAL	4	$2,625.00
INTRON A 18MMU VIAL	1	$977.54
INTRON A 3MMU INJECTION PEN	2	$924.98
INTRON A 3MMU/0.5ML KIT	2	$1,432.01
INTRON A 5MMU INJECTION KIT	1	$545.17
INTRON A 5MMU/0.5ML KIT	5	$3,075.59
PEGASYS 180MCG/ML VIAL	1	$1,306.90
PEG-INTRON 120MCG KIT	52	$58,755.33
PEG-INTRON 150MCG KIT	106	$116,600.79
PEG-INTRON 50MCG KIT	10	$9,618.28
PEG-INTRON 80MCG KIT	62	$66,636.34
REBETRON 1000 THERAPY PAK	10	$14,451.98
REBETRON 1200 THERAPY PAK	16	$14,205.77
REBETRON 600 THERAPY PAK	3	$1,714.62
GRAND TOTAL	276	$294,469.11